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AIDS in Prisons and Jails: Issues and Options

Theodore M. Hammett

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Acquired Immunodeficiency Syndrome (AIDS) has rapidly become one of the most difficult and complex public health issues facing the United States. Since AIDS was first identified in this country in 1981, over 17,000 Americans have developed the disease. The rapid increase in cases, particularly in the past 2 years, and the continued uncertainties as to the future course of the disease's spread have led the President to term AIDS "the Nation's number one health priority."

In the correctional context, dealing with the problem of AIDS may pose even more difficult problems since inmate populations may include high proportions of individuals in AIDS risk groups, particularly intravenous drug users. Correctional administrators must formulate policies that allow them to manage their institutions effectively, while dealing with a serious health problem that may cause fears among staff and inmates. Administrators face difficult decisions concerning prevention, housing, and the provision of medical care, decisions which are frequently complicated by legal and cost issues.

In response to urgent information needs expressed by corrections professionals, the National Institute of Justice and the American Correctional Association sponsored a study entitled *AIDS in Correctional Facilities: Issues and Options*. The study was based, in large part, on responses to a national mail questionnaire from all 50 State correctional departments, the Federal Bureau of Prisons, and 33 large city and county jail systems. The responses were received between November 1985 and January 1986.

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From the Director

Acquired Immunodeficiency Syndrome (AIDS) represents a serious challenge for American correctional systems.

Recognizing that many inmate populations contain a high concentration of individuals at risk for the disease—primarily because of histories of intravenous drug use and, to a lesser degree, homosexual behavior—correctional administrators are concerned with developing effective policies to ensure the health and safety of both inmates and staff.

Often already coping with crowded institutions and limited budgets, they face difficult decisions regarding prevention, institutional management, and the identification and treatment of inmates with AIDS. These decisions are further complicated by a range of legal issues, the high costs of medical care and the need to control fear and misinformation throughout the institution.

Recognizing the potential scope of these problems, many correctional administrators have expressed interest in receiving information that can help them in formulating policies on AIDS. To address this need, the National Institute of Justice and the American Correctional Association jointly sponsored the development of a report entitled *AIDS in Correctional Facilities: Issues and Options*.

Given the urgency of the need, the study was an intensive effort, conducted over a 4-month time period. In addition to the dedication of the project director, Theodore M. Hammett, the cooperation of the National Institute of Corrections, the Association of State Correctional Administrators, the Centers for Disease Control, and the American Correctional Association should be recognized.

This *Research in Brief* summarizes the major findings and conclusions of the full report. Like the full report, it is intended to be informational rather than prescriptive.

Certain principles, such as the importance of inmate and staff education on AIDS, are indisputable. Still, there are many other issues and policy questions that continue to spur debate both within and between the correctional and medical communities.

By outlining these debates and providing the most current information available, the National Institute of Justice and ACA hope that correctional administrators will be better equipped to deal with the problem of AIDS.

James K. Stewart
Director
National Institute of Justice

The study summarizes the latest medical information on AIDS, presents statistics on the incidence of AIDS in correctional facilities, and enumerates the key issues and options facing correctional administrators as they formulate policy responses to this complex problem. This Research in Brief summarizes the major findings and conclusions of that report.

Cause and transmission of AIDS

AIDS is a serious communicable disease that undermines the human body's ability to combat infections. In 1983 and 1984, the probable cause of AIDS—variously called human t-cell lymphotropic virus type III (HTLV-III) and lymphadenopathy-associated virus (LAV)—was identified. Thus far, most cases in the United States have been among homosexuals and intravenous drug abusers, with cases primarily concentrated in large metropolitan areas on the east and west coasts.

End-stage AIDS is almost always fatal. However, a range of milder forms of illness, sometimes called AIDS-Related Complex (ARC), may also appear among those infected with the AIDS virus.

Infection with HTLV-III is transmitted through contaminated blood and semen, primarily during sexual activity and needle-sharing related to intravenous drug abuse. The virus is difficult to transmit and there is absolutely no evidence of its transmission through casual contact, such as coughing, hugging, handshaking, sharing eating and drinking utensils, or using the same toilet facilities.

In 1985, a test was developed and made widely available to detect the presence of antibodies (evidence of the body's attempt to fight off an infection) to HTLV-III. While the test does not detect the presence of the virus itself, seropositivity (i.e, presence of antibodies) means that an individual has been infected with the AIDS virus at some time, although the body may have subsequently fought off the infection.

The likelihood that HTLV-III seropositivity means current infection with the virus is considered much greater for individuals in identified AIDS risk groups (e.g., homosexual or bisexual males, intravenous drug abusers). Nevertheless, seropositive individuals may never develop any symptoms, let alone develop end-stage AIDS.

Currently, the Centers for Disease Control (CDC) estimate that 5 to 6 percent of seropositive individuals will develop end-stage AIDS while another 25 percent will develop ARC. However, recent research suggests that the percentage of seropositive individuals who will develop AIDS may be somewhat higher. Moreover, CDC cautions that seropositive individuals may be able to transmit the infection to others, even if they never develop symptoms themselves. Exhibit 1 summarizes the relationships among exposure, infection, seropositivity, ARC, and AIDS.

AIDS in the correctional population

Responses to the study questionnaire reveal that, since 1981, there have been a cumulative total of 455 confirmed AIDS cases in 25 State and Federal prison systems. Twenty large city and county jail systems reported 311 cases of AIDS among inmates. These figures represent *cumulative* total cases since the responding jurisdictions began keeping records.

As of the period November 1985 to January 1986, there were 144 cases of

Exhibit 1

Relationships among exposure, infection, HTLV-III seropositivity, and development of ARC or AIDS

Stage	Meaning	Relationship to previous stage(s)
Exposure	Individual has contact with HTLV-III in a way that makes transmission possible (e.g., sexual contact or needle-sharing activity)	—
Infection	Individual is infected with HTLV-III. Infection may be permanent or body may successfully combat the virus.	Unknown, although multiple exposures probably increase the risk of infection.
Seropositivity	Individual has antibodies to HTLV-III. Infection has occurred at some time in the past, but date of infection or whether individual remains infected cannot be determined.	CDC considers the HTLV-III antibody test a reliable indicator that infection has occurred at some time. Repeat and confirmatory testing increase reliability.
ARC	A combination of conditions that together give evidence of infection with AIDS virus.	About 25 percent of seropositive individuals will probably develop ARC (CDC estimate). This estimate is uncertain due to the lengthy incubation period.
AIDS	Illness characterized by one or more opportunistic infections at least moderately indicative of underlying cellular immunodeficiency.	About 5 to 6 percent of seropositive individuals will probably develop AIDS. (CDC estimate). Recent studies place the fraction as high as one-third. Again, all estimates are uncertain due to the lengthy incubation period.

Opinions or points of view expressed in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

AIDS among State and Federal inmates in 19 systems and 35 cases among city and county inmates in 11 systems.

No known AIDS cases have occurred among correctional staff as a result of contact with inmates. Questionnaire respondents reported nine cases of AIDS among current or former staff, but none of these individuals had been involved in an incident with an inmate in which transmission of the AIDS virus might have occurred. Indeed, most were known or suspected to have been in AIDS risk groups.

The distribution of AIDS cases across correctional systems is highly skewed (Exhibit 2). Fifty-one percent of the prison systems have had *no* cases and 80 percent have had fewer than four cases. Among responding city and county jail systems, 39 percent have had no cases and 70 percent have had fewer than four cases.

At the other extreme, two State prison systems and only one of the responding city and county jail systems have had more than 50 cases. The regional distribution is also highly uneven. Over 70 percent of the cases, both in State prison systems and in city and county jail systems, have occurred in the mid-Atlantic region, with all other parts of the United States contributing much smaller percentages.

The vast majority of correctional AIDS cases, particularly in jurisdictions with large numbers of cases, are believed to be associated with prior intravenous drug abuse. There is substantial debate, but little hard data, on the extent to which the AIDS virus is being transmitted within correctional institutions. The two primary means of transmission are prohibited behavior in all corrections systems. However, logic and common sense suggest that, even in the best-managed correctional facilities, there may be at least some transmission of the infection occurring among inmates.

Correctional policy issues and options

The major policy areas involved in the correctional response to AIDS are education and training; HTLV-III antibody testing; and medical, legal, and correctional management issues.

Exhibit 2

Distribution of cumulative total AIDS cases among inmates, by type of system

Range of total AIDS cases	State/Federal prison systems				City/county jail systems			
	n systems	%	n cases	%	n systems	%	n cases	%
0	26	51%	0	0%	13	39%	0	0%
1-3	15	29	24	5	10	30	16	5
4-10	5	10	30	7	7	21	43	14
11-25	2	4	42	9	1	3	12	4
26-50	1	2	33	7	1	3	40	13
51-100	1	2	95	21	0	0	0	0
› 100	1	2	231	51	1	3	200	64
TOTAL	51	100%	455	100%	33	99%[a]	311	100%

Source: NIJ/ACA questionnaire responses

[a] Due to rounding

Education and training

Because there is no vaccine or cure for the disease, education and training programs are the cornerstone of efforts to curb the spread of AIDS in prisons and jails, as well as in the population at large. Education and training programs also provide the opportunity to counteract misinformation, rumors, and fear concerning the disease. For example, the majority of systems responding to the questionnaire reported that inmates and staff worried about the possibility of contracting AIDS; many responses referred to fear of casual contact or types of contact not actually associated with transmission of the virus.

As a result, many correctional administrators feel strongly that education and training are not options but absolute requirements. Ninety-three percent of the responding jurisdictions currently offer or are developing AIDS educational programs for staff; 83 percent offer or are developing such programs for inmates.

Among respondents whose educational programs have operated for some time, the vast majority believe these programs to be effective in reducing the fears of staff and inmates. Several jurisdictions reported that timely educational efforts had successfully averted threatened job actions by correctional staff unions.

Experience suggests that training and education programs should be instituted before deep-seated fears have developed, and repeated periodically so that the latest medical information can be presented and new staff and inmates can be reached on a timely basis.

Effective education programs may include live presentations by training teams, printed materials, and videotapes. Program curricula and materials should be brief, clear, and straightforward and tailored to the particular knowledge gaps and concerns of the audience. They should discuss the means of transmission of the AIDS virus and emphasize everyone's responsibility to avoid behaviors known to be associated with transmission. They should also guard against encouraging a false sense of security in

any group. At the same time, programs should not create needless fear by advocating unnecessary precautionary measures.

HTLV-III antibody testing

There is substantial debate, both in corrections and in society at large, surrounding the uses of the HTLV-III antibody test and the meaning of the test results. The most controversial testing application in corrections is mass screening: the testing of all inmates or all new inmates, regardless of the presence of symptoms or other clinical indications.

Correctional policies on HTLV-III antibody testing. Only four State correctional systems (Nevada, Colorado, Iowa, and Missouri) have implemented or plan to implement mass screening programs for inmates; no city or county systems responding to the questionnaire have instituted or planned such programs. However, almost 90 percent of the responding jurisdictions do employ testing for more limited purposes. These include testing of risk-group members, testing in support of diagnoses of AIDS or ARC, testing in response to incidents in which the AIDS virus might have been transmitted, testing on inmate request, and testing carried out as part of anonymous epidemiological studies. Exhibit 3 summarizes study findings on correctional testing policies.

Mass screening: the debate. The debate over mass screening for antibody to HTLV-III in correctional institutions involves the following major questions:

- *Should correctional systems take steps not being taken in the community at large?*

Proponents of testing argue that rates of HTLV-III seropositivity are higher among inmates and that the virus is likely to be transmitted within institutions; they believe that screening is necessary to identify infectious individuals and to target prevention programs.

Opponents argue that there is no proof of higher rates of HTLV-III transmission in prison and therefore there is no legitimate reason to screen.

Exhibit 3

Summary of responding jurisdictions' HTLV-III antibody testing policies for inmates[a]

Policy category	State/Federal prison systems		City/county jail systems	
	n	%	n	%
• Mass screening (all or all new inmates)	4	8%	0	0%
• Screening of risk groups	2	4	7	21
• Testing *only* for diagnoses, incident response, or epidemiological studies	39	77	20	61
• Testing *only* on inmate request	1	2	1	3
• No testing	5	10	5	15
TOTAL	51	101%[b]	33	100%

[a]Includes actual and planned policies. This is a hierarchical categorization. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that do screening of all members of at least some risk groups, but no mass screening, are placed in the "screening of risk groups" category regardless of whether they also do testing for diagnosis, incident response, or epidemiology studies.

[b]Due to rounding.

- *What are the policy implications of identifying seropositive individuals?*

Proponents of screening argue that seropositive individuals must be identified so they can be given special supervision, counseling, and other programming.

Opponents argue that mass identification of seropositives would serve no purposes not better addressed by educational programs and would, in fact, create significant correctional management problems—particularly if large numbers of seropositives were identified and there was irresistible pressure to segregate them.

- *How would mass screening affect education and prevention programs?*

Proponents argue that screening is necessary to inform and target education and prevention programs.

Opponents argue that screening needlessly and misleadingly divides the inmate population into a stigmatized class and a "safe" class, thereby undermining the important educational message that everyone should be careful.

- *Is it possible to develop a reliable and confidential screening program?*

Proponents argue that the antibody test is reliable and that confidentiality of results can be maintained.

Opponents argue that the test results are often unreliable and that real and rumored results would inevitably become known to the inmate population and others outside the institution, potentially subjecting actual or supposed seropositives to threats and intimidation while in prison and to discrimination in housing, employment, and insurability after discharge.

- *What are the legal implications of screening?*

Proponents argue that mass screening is legal and proper and, in fact, that failure to conduct mass screening may result in serious legal liabilities.

Opponents point out that laws and policies requiring subjects' informed consent for HTLV-III antibody testing preclude mandatory mass screening and suggest that liability issues can be effectively managed.

- *What are the costs of mass screening?*

Proponents of screening argue that the test can be economically administered.

Opponents argue that when the costs of repeat and confirmatory tests and the costs of separate correctional programming for seropositives are included, the total price could become prohibitive, particularly for large systems and/or those likely to identify large numbers of seropositive inmates.

- *Will mass screening allay or inflame fears?*

Proponents argue that screening could help to calm the concerns of inmates and staff if it found low rates of seropositivity. Moreover, regardless of the seropositivity rates, failure to screen could cause serious public relations problems.

Opponents argue that mass screening will needlessly inflame fears, particularly if the seropositivity rate is found to be high.

- *Are there feasible alternatives to screening?*

Proponents argue that screening is the best method of obtaining the necessary information on HTLV-III seropositivity and transmission.

Opponents argue that there are better ways to identify high-risk individuals and diagnose AIDS and ARC that avoid the negative consequences of mass screening. These include astute medical surveillance and alternative laboratory work for diagnoses.

In addition, anonymous epidemiological studies may permit estimation of HTLV-III seropositivity and transmission rates while avoiding the correctional management and confidentiality problems of mass screening.

Implementation issues. Correctional administrators who decide to implement any mass or selective testing program face a range of issues, including when and where to administer the test, and whether testing should be voluntary, mandatory, or on request.

In 60 percent of the responding jurisdictions, all testing is either voluntary or on inmate request. In 15 percent of the jurisdictions, all testing is mandatory.

There are serious legal and ethical issues involving both whether inmates can be compelled to submit to testing and whether they have a right to testing on request. Laws in some jurisdictions (e.g., California and Wisconsin) prohibit HTLV-III antibody testing without the informed consent of the subject.

Those who oppose mandatory testing argue that, because of the potentially serious negative effects of testing (e.g., discrimination in housing, employment, insurability), medical ethics require that there be a right of refusal, regardless of law or policy.

Some also argue that correctional systems have an obligation to provide the test to any or all inmates who request it. However, if such testing is provided, many physicians believe that inmates should be fully and accurately informed of the potential personal and psychological effects of testing before they make any decisions and that those who are tested be counseled on the meaning and implications of the results.

Medical, legal, and correctional management issues

Correctional administrators responding to the challenging problem of AIDS in prisons and jails must balance medical considerations and medical advice against complex correctional management factors. Decisionmaking is further complicated by legal and cost concerns. The following section discusses these issues.

Medical issues. Perhaps the highest priority in the correctional response to AIDS is providing timely, professional, and compassionate medical care to inmates who become ill with the disease. As in society at large, prompt detection and diagnosis are needed to minimize spread of the disease and alleviate the suffering of patients.

Whether or not HTLV-III testing is used, appropriate diagnostic workups are necessary to identify immunosuppression, ARC, and AIDS. Also, certain tests may be able to detect early evidence of opportunistic infections typically seen in AIDS patients.

Careful surveillance and regular followup are extremely important for patients with AIDS, ARC, and HTLV-III seropositivity, since life-threatening symptoms can develop very quickly. Because AIDS patients experience serious psychological as well as physical problems, counseling and support systems involving correctional staff and family members are also considered important components of care.

Correctional management issues. Ironically, the medical treatment of AIDS patients may be the simplest issue confronting correctional administrators. Other questions—where to house and treat the inmate, how to prevent the spread of the disease, and how to pay for medical care—are likely to be even more difficult to resolve.

Housing policies. One of the most critical and difficult decisions for correctional administrators is where to house and treat inmates with AIDS, ARC, or HTLV-III seropositivity. Of course, medical considerations dictate many of these decisions. Most jurisdictions place inmates with confirmed diagnoses of AIDS in a medical facility either within the correctional system or in the community, although the duration of such hospitalization varies considerably.

Preventing the spread of AIDS within the prison and protecting affected inmates from intimidation and violence are important considerations. Other factors in treatment and housing decisions include availability and location of facilities able to provide appropriate care, costs of any new construction or renovations necessary to prepare special units, and staffing of any special AIDS units (correctional as well as medical).

Correctional administrators have a number of options concerning treatment and housing placements for inmates with AIDS, ARC, or HTLV-III seropositivity. The key options are the following:

1. maintaining inmates in the general population;

2. returning inmates to the general population when their illnesses are in remission;

3. administratively segregating inmates in a separate unit or relying on single-cell housing;

4. hospitalization; and

5. case-by-case determination of all housing and treatment decisions.

Exhibit 4 summarizes the housing policies of the responding systems. Two-thirds of the Federal and State systems, and 70 percent of responding city and county systems have written policies in place or in development for managing inmates with AIDS, ARC, and HTLV-III seropositivity.

Most jurisdictions hospitalize or administratively segregate at least some of the three AIDS-related inmate categories.

City and county jurisdictions are more likely to use segregation: 39 percent of responding city and county jail systems segregate all three AIDS-related inmate categories, as opposed to only 16 percent of State and Federal prison systems. Almost one-third of all responding systems have basic policies involving case-by-case determination of treatment and housing programs.

While Exhibit 4 indicates the wide variation in correctional policies on housing and treatment of inmates with AIDS, the four jurisdictions with almost 75 percent of the correctional AIDS cases (New York State, New York City, New Jersey, and Florida) all follow the same combination of policies:

1. medical segregation of AIDS patients, but no segregation of inmates with ARC or HTLV-III seropositivity;

2. careful evaluation and ongoing monitoring of inmates suspected of having ARC or AIDS;

3. no mass screening for antibody to HTLV-III; and

4. extensive staff and inmate educational programs.

All four of these systems report that equilibrium has been reached on the AIDS issue, with no widespread fear among staff or inmates regarding transmission of the virus within the institutions.

Precautionary measures. Correctional agencies have adopted a wide range of precautionary measures to control spread of AIDS within institutions; many are based on Centers for Disease Control guidelines for clinical staff.[1] The CDC guidelines advise clinical and laboratory staff "to use the same precautions when caring for patients with AIDS as those used for patients with hepatitis-B virus infection...Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin or mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS."

Several physicians interviewed for this study believe that, since the AIDS virus is less hardy and more difficult to transmit than the hepatitis-B virus, precautions designed to prevent transmission of hepatitis-B should more than suffice to prevent transmission of AIDS.

Some correctional agencies have instituted precautionary measures which go far beyond those recommended by CDC. Many of these measures are designed to limit exposure under extremely unusual circumstances or to prevent exposure through casual contact. However, all evidence indicates that AIDS cannot be transmitted by a single exposure of any kind or through casual contact. This is a major theme in most AIDS education programs.

Precautionary measures addressing very rare or casual modes of contact, even if implemented in a good faith effort to reduce the fears of staff and inmates, may ultimately increase those fears by encouraging the view that the disease is spread by the very sort of unusual or casual contacts they seek to prevent. Such a conflict between educational messages and practical measures may not only increase fear within the institution, but also may foster suspicion of the correctional

Exhibit 4

Summary of responding jurisdictions' housing policies[a] for inmates with AIDS, ARC, and HTLV-III seropositivity

Policy combination	State/Federal prison systems		City/county jail systems	
	n	%	n	%
• Segregate AIDS cases; ARC cases and seropositives maintained in general population	3	6%	3	9%
• Segregate AIDS and ARC cases; seropositives maintained in general population	10	20	3	9
• Segregate all categories	8	16	13	41
• No segregation of any categories	2	4	0	0
• No policy	8	16	1	3
• Combinations involving case-by-case determination	16	31	10	30
• Other policy combinations	4	8	3	9
TOTAL	51	101%[b]	33	101%[b]

[a]For the purposes of this categorization, segregation means that the *basic* policy is to hospitalize (either within or outside the correctional system) or to segregate administratively the particular category of inmate, regardless of whether these inmates are returned to the general population when their symptoms subside. Single-celling is also included in segregation.

[b]Due to rounding.

[1]CDC, *Morbidity and Mortality Weekly Report (MMWR)* 1982; 31:577–580; see also *MMWR* 1985; 34: 681–695.

system for, in effect, saying one thing about the transmission of AIDS but doing something else.

Notification and confidentiality. One of the most difficult and sensitive issues regarding AIDS in corrections is who receives information on the medical status of inmates with AIDS, ARC, or HTLV-III seropositivity. Decisions regarding who should receive HTLV-III antibody test results and who should be notified of AIDS or ARC diagnoses may be dictated by precise legal and policy standards such as requirements for written authorization to release test results or other medical records.

Two-thirds of State and Federal prison systems and 91 percent of responding city and county jail systems have general or specific confidentiality policies covering AIDS-related medical information.

Some argue that decisions regarding disclosure versus confidentiality of medical information in cases of AIDS or ARC should be based solely on legal requirements—that is, no information should be reported to anyone unless it is required by law. This position is based on the premise that correctional systems should bear no greater responsibility for notification than do institutions in the community at large.

Where law or policy allows any discretion, decisions regarding disclosure versus confidentiality invariably raise the question of which should take precedence: the inmate's right to have medical information kept confidential or the correctional system's perceived legal and moral responsibility to protect its staff and other inmates, as well as the public, from HTLV-III infection.

There are valid claims on both sides. On the one hand are arguments that correctional staff have a right to know when they are dealing with inmates who may be infectious or who have a serious communicable disease, and that other inmates, spouses, or sexual partners have a right to know who may be carrying a sexually transmitted disease. Notification to public health departments and inmates' former and/or subsequent correctional systems may also be considered important to facilitate treatment, prevention measures, and contact tracing. Such disclosures may also be designed to reduce or eliminate the correctional system's legal liability should a released or transferred inmate transmit AIDS to others.

On the other hand, the most compelling reason for maintaining confidentiality is that persons known to have AIDS, ARC, or HTLV-III seropositivity may suffer ostracism, threats, and possibly violent intimidation while in prison, and discrimination in employment, housing, and insurance availability after they are discharged.

Because of their rapid population turnover rates, jails face even more difficult policy decisions and logistical problems regarding disclosure and confidentiality of medical information.

The most notable study finding regarding disclosure is that a relatively small number of systems provide test results to inmates (31 percent of State and Federal systems and 52 percent of responding city and county systems). No State or Federal system and a small fraction of city-county systems (19 percent) disclose results to inmates *only*. Seventy percent of State and Federal systems and 61 percent of responding city and county systems provide results to medical staff.

No jurisdictions responding to the questionnaire specifically reported that spouses or sexual partners or previous correctional facilities of seropositive inmates are notified of test results.

Costs of care and associated services. Questionnaire responses showed that correctional systems are almost universally concerned about the costs of medical care and associated services for inmates with AIDS. Questions regarding range of costs elicited widely varying estimates, but all agreed that medical care for AIDS patients is extremely expensive, whether it is provided in a correctional medical facility, in another public medical facility, or in a hospital in the community, particularly because correctional inmates are ineligible for Medicaid reimbursement.

Correctional systems should plan on spending anywhere from $40,000 to over $600,000 for hospitalization and associated medical costs of caring for each inmate with AIDS.[2] The costs will vary depending on the amount of acute care required; they will also probably be higher if inmates are placed in hospitals in the community than if they are retained in correctional medical facilities or other public medical facilities.

To the figures for hospitalization and medical care must be added costs of ancillary services such as counseling, possible legal assistance, increased insurance (unless the system is self-insured), and funerals. Obviously, medical care and associated services for inmates with AIDS could have serious budgetary implications for correctional systems.

Legal issues. There is currently very little law specifically on correctional systems' policies regarding AIDS cases, though several cases have been filed in New York and other States. Otherwise, specific AIDS-related legal concerns remain largely hypothetical. Still, there is substantial caselaw on correctional medical care in general, which is important for administrators to consider in developing policies regarding AIDS.

Suits on the quality of correctional medical care[3] may be brought on the basis of Federal constitutional standards, State law, or common law. There are three constitutional principles relevant to correctional medical care.

First, under the eighth amendment, inmates are entitled to a safe, decent, and humane environment.[4] Second, in *Estelle v. Gamble*,[5] "deliberate indifference to serious medical need" was held to violate the eighth amendment protection against "cruel and unusual punishment." Finally, the constitutional guarantee of "equal protection of the laws" applies to correctional medical care cases, and particularly to

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[2]The low figure is from "Special Report: The AIDS Epidemic," *New England Journal of Medicine* 1985; 312:523; the high figure is based on 2 years at New York City's annual estimate of $300,000 for patients requiring acute care.

[3]This discussion is based largely on the presentation of Clair Cripe, Esq., of the Federal Bureau of Prisons, at a meeting of Correctional Commissioners on AIDS, sponsored by the National Institute of Corrections, Atlanta, Georgia, November 6, 1985.

[4]See, e.g., *Rhodes v. Chapman*, 452 US 337 (1981).

[5]429 US 97 (1976).

cases involving AIDS inmates, because of the segregation issues.

Medical care in correctional institutions is usually governed by the same State laws (e.g., medical practice and nursing practice acts) that apply to care in the community at large. Finally, in some States, correctional medical care may be subject to suits for common law torts such as negligence. Medical malpractice suits are also a possibility.

Existing caselaw on AIDS in correctional facilities falls into the following three major categories:

1. Equal protection. Cases filed by inmates alleging denial of equal protection based solely on the fact that they had AIDS (e.g., *Cordero v. Coughlin*).[6] This case was decided in favor of the correctional department.

2. Quality of care. Cases filed by inmates alleging inadequacies in medical care and associated services (e.g., *Storms v. Coughlin*).[7]

3. Failure to protect others from AIDS. Cases filed by inmates and potentially also by staff alleging inadequate protective measures and seeking additional steps such as mass screening of inmates and segregation of inmates with AIDS, ARC, or HTLV-III seropositivity (e.g., *Mtr La Rocca v. Dalsheim*).[8] The *La Rocca* case was decided in favor of the correctional department; other cases on these issues are still pending.

AIDS poses complex and difficult problems for correctional systems. The only certainty is that the problems will not disappear. Every correctional system should develop comprehensive policies and procedures for managing the AIDS problem in its institutions. The information provided here and in the full report can help correctional administrators consider the range of options available and the strengths and weaknesses of each.

Theodore M. Hammett was project director for Abt Associates, Inc., in the urgent 4-month study that led to this condensed report. To learn about availability of the full report, call the National Institute of Justice/ NCJRS at 800–851–3420 and give the title and identifying number, NCJ 100126. (From Alaska, Maryland, and the Metropolitan Washington, D.C., area, call 301–251–5500.)

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[6] 607 F Supp 9 (S.D.N.Y., 1984)

[7] *Storms v. Coughlin* was filed in U.S. District Court for the Southern District of New York. Some of the issues may be mooted by new State regulations, but the plaintiff's attorney believes that there are a number of important quality-of-care issues to litigate. See also *Thagard v. County of Cook*, unreported opinion: No. 85 C 4429 (N.D. Ill., May 20, 1985).

[8] 120 Misc 2d 697 (N.Y. 1983). See also *Herring v. Keeney* (U.S.D.C., Oregon, filed September 17, 1985); *Sheppard v. Keeney* (U.S.D.C., Oregon, filed October 7, 1985); *Malport v. Keeney* (U.S.D.C., Oregon, filed October 11, 1985); *Telepo et al. v. Kean et al.* Civil Action 85-1742A(U.S.D.C., New Jersey, filed May 1985).

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